

**Application for Section
1915(b)(4) Waiver Fee-for-
Service Selective Contracting
Program**

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Facesheet

The State of Maryland requests a waiver/amendment under the authority of section 1915(b) of the Act. The Medicaid agency will directly operate the waiver.

The name of the waiver program is Home and Community-Based Options (formerly known as Waiver for Older Adults).

Type of request. This is:

an initial request for new waiver.

a request to amend an existing waiver, which modifies Section/Part A.

a renewal request

Section A is: replaced in full

carried over with no changes

changes noted in **BOLD**.

Section B is: replaced in full

changes noted in **BOLD**.

Effective Dates: This waiver renewal is requested for the period of **4/1/2022 to 6/30/2026**.

State Contact: The State contact person for this waiver is **Marlana Hutchinson, Director, Office of Long Term Services and Supports**, and can be reached by telephone at (410) 767-1443 or e-mail at **marlana.hutchinson@maryland.gov**.

Section A – Waiver Program Description

Part I: Program Overview

Tribal Consultation:

Describe the efforts the State has made to ensure that Federally-recognized tribes in the State are aware of and have had the opportunity to comment on this waiver proposal.

In accordance with Section 1902(a)(73) of the Social Security Act, Maryland Medicaid seeks advice on a regular, ongoing basis from designees including Maryland's Urban Indian Organization (**UIO**). In November 2010, the State appointed a designee of the **UIO** to the Maryland Medicaid Advisory Committee (MMAC). The MMAC meets monthly and receives updates on demonstration projects, pertinent policy issues, waivers, regulations and State Plan Amendments (SPAs) for all Medicaid Programs. These communications occur prior to the submission of waivers, amendments and other policy changes. Maryland also consults with the UIO on an as needed basis to develop SPAs and regulations, which will have a direct impact on access to health care systems as well as the provision of care/services for Indian populations.

On April 29, 2021, May 7, 2021 and November 16, 2021, the State contacted the UIO about this renewal. The UIO is currently reviewing this application and the organization's response will be noted upon submission of this application to the Centers for Medicare and Medicaid Services (CMS).

Program Description:

Provide a brief description of the proposed selective contracting program or, if this is a request to amend an existing selective contracting waiver, the history of and changes requested to the existing program. Please include the estimated number of enrollees served throughout the waiver.

The waiver request is limited to the case management services in the existing 1915(c) waiver, Home and Community-Based Options. This waiver provides services, including case management, to adults ages 18 and over who meet nursing facility level of care. Under the 1915(b)(4) authority, the State currently waives the freedom of choice of providers for case management services offered under the 1915(c) authority. The Area Agencies on Aging (AAAs) will **continue to** be designated providers. **Maryland will continue to utilize the** competitive solicitation process to identify one **(1)** or more providers per region to offer a limited choice of providers to the participants within each region.

Waiver Services:

Please list all existing State Plan services the State will provide through this selective contracting waiver.

A. Statutory Authority

1. Waiver Authority. The State seeks authority under the following subsection of 1915(b):

X 1915(b) (4) - FFS Selective Contracting program

2. Sections Waived. The State requests a waiver of these sections of 1902 of the Social Security Act:

- a. ___ Section 1902(a) (1) - Statewideness
- b. ___ Section 1902(a) (10) (B) - Comparability of Services
- c. Section 1902(a) (23) - Freedom of Choice
- d. ___ Other Sections of 1902 - (please specify)

B. Delivery Systems

1. Reimbursement. Payment for the selective contracting program is:

- ___ the same as stipulated in the State Plan
- is different than stipulated in the State Plan (please describe)

In accordance with **Code of Maryland Regulations (COMAR) 10.09.54.22**, a fee schedule shall be published at least annually by the Department, and the rates are increased on July 1 of each year, subject to the limitations of the State budget, by the lesser of **3%** or the percentage of the annual increase in the March Consumer Price Index for All Urban Consumers, all items component, Washington-Baltimore, from the U.S. Department of Labor, Bureau of Labor Statistics. The Office of **Long Term Services and Supports** implements rate adjustments in accordance with these regulatory provisions.

2. Procurement. The State will select the contractor in the following manner:

- ___ Competitive procurement
- ___ Open cooperative procurement
- ___ Sole source procurement
- Other (please describe)

The State will designate up to 19 AAAs. **The State utilizes a** competitive solicitation process to identify additional providers, **as needed**. Since the rates **are** set in regulation, the proposals **are** evaluated solely on quality and experience.

C. Restriction of Freedom of Choice

1. Provider Limitations.

- ___ Beneficiaries will be limited to a single provider in their service area.
- Beneficiaries will be given a choice of providers in their service area.

Supports Planning Agencies (SPAs) are identified through a competitive solicitation process. The State intends to have at least two **(2)** providers per county. Montgomery County has **seven (7)** SPAs **in addition to the AAA**; all other counties have **four (4)** SPAs.

County										
Allegany County, Maryland	Area Agencies on Aging (AAA)	Medical Management and Rehabilitations Services (MMARS)	The Coordinating Center (TCC)	Total Care Sevices (TCS)	Beatrice Loving Heart (BLH)	Service Coordination Inc. (SCI)				
Anne Arundel County, Maryland	Area Agencies on Aging (AAA)	Medical Management and Rehabilitations Services (MMARS)	The Coordinating Center (TCC)	Total Care Sevices (TCS)	Beatrice Loving Heart (BLH)	Service Coordination Inc. (SCI)		Southern Maryland Center for Independent Living (SMCIL)		
Baltimore, Maryland	Area Agencies on Aging (AAA)	Medical Management and Rehabilitations Services (MMARS)	The Coordinating Center (TCC)	Total Care Sevices (TCS)	Beatrice Loving Heart (BLH)	Service Coordination Inc. (SCI)			WJ Community Integration Services, LLC (WJCIS)	
Baltimore County, Maryland	Area Agencies on Aging (AAA)	Medical Management and Rehabilitations Services (MMARS)	The Coordinating Center (TCC)	Total Care Sevices (TCS)	Beatrice Loving Heart (BLH)	Service Coordination Inc. (SCI)			WJ Community Integration Services, LLC (WJCIS)	
Calvert County, Maryland	Area Agencies on Aging (AAA)	Medical Management and Rehabilitations Services (MMARS)	The Coordinating Center (TCC)	Total Care Sevices (TCS)	Beatrice Loving Heart (BLH)	Service Coordination Inc. (SCI)		Southern Maryland Center for Independent Living (SMCIL)		
Caroline County, Maryland	Area Agencies on Aging (AAA)	Medical Management and Rehabilitations Services (MMARS)	The Coordinating Center (TCC)	Total Care Sevices (TCS)				Bay Area Center for Independent Living (BACIL)		
Carroll County, Maryland	Area Agencies on Aging (AAA)	Medical Management and Rehabilitations Services (MMARS)	The Coordinating Center (TCC)	Total Care Sevices (TCS)	Beatrice Loving Heart (BLH)	Service Coordination Inc. (SCI)				
Cecil County, Maryland	Area Agencies on Aging (AAA)	Medical Management and Rehabilitations Services (MMARS)	The Coordinating Center (TCC)	Total Care Sevices (TCS)				Bay Area Center for Independent Living (BACIL)		
Charles County, Maryland	Area Agencies on Aging (AAA)	Medical Management and Rehabilitations Services (MMARS)	The Coordinating Center (TCC)	Total Care Sevices (TCS)	Beatrice Loving Heart (BLH)	Service Coordination Inc. (SCI)		Southern Maryland Center for Independent Living (SMCIL)		
Dorchester County, Maryland	Area Agencies on Aging (AAA)	Medical Management and Rehabilitations Services (MMARS)	The Coordinating Center (TCC)	Total Care Sevices (TCS)				Bay Area Center for Independent Living (BACIL)		
Frederick County, Maryland	Area Agencies on Aging (AAA)	Medical Management and Rehabilitations Services (MMARS)	The Coordinating Center (TCC)	Total Care Sevices (TCS)	Beatrice Loving Heart (BLH)	Service Coordination Inc. (SCI)				
Garrett County, Maryland	Area Agencies on Aging (AAA)	Medical Management and Rehabilitations Services (MMARS)	The Coordinating Center (TCC)	Total Care Sevices (TCS)	Beatrice Loving Heart (BLH)	Service Coordination Inc. (SCI)				
Harford County, Maryland	Area Agencies on Aging (AAA)	Medical Management and Rehabilitations Services (MMARS)	The Coordinating Center (TCC)	Total Care Sevices (TCS)	Beatrice Loving Heart (BLH)	Service Coordination Inc. (SCI)				
Howard County, Maryland	Area Agencies on Aging (AAA)	Medical Management and Rehabilitations Services (MMARS)	The Coordinating Center (TCC)	Total Care Sevices (TCS)	Beatrice Loving Heart (BLH)	Service Coordination Inc. (SCI)				
Kent County, Maryland	Area Agencies on Aging (AAA)	Medical Management and Rehabilitations Services (MMARS)	The Coordinating Center (TCC)	Total Care Sevices (TCS)				Bay Area Center for Independent Living (BACIL)		
Montgomery County, Maryland	Area Agencies on Aging (AAA)	Medical Management and Rehabilitations Services (MMARS)	The Coordinating Center (TCC)	Total Care Sevices (TCS)	Beatrice Loving Heart (BLH)	Service Coordination Inc. (SCI)			WJ Community Integration Services, LLC (WJCIS)	Independence Now (IN)

County										
Prince George's County, Maryland	Area Agencies on Aging (AAA)	Medical Management and Rehabilitations Services (MMARS)	The Coordinating Center (TCC)	Total Care Sevices (TCS)	Beatrice Loving Heart (BLH)	Service Coordination Inc. (SCI)		Southern Maryland Center for Independent Living (SMCIL)	WJ Community Integration Services, LLC (WJCIS)	
Queen Anne's County, Maryland	Area Agencies on Aging (AAA)	Medical Management and Rehabilitations Services (MMARS)	The Coordinating Center (TCC)	Total Care Sevices (TCS)			Bay Area Center for Independent Living (BACIL)			
Somerset County, Maryland	Area Agencies on Aging (AAA)	Medical Management and Rehabilitations Services (MMARS)	The Coordinating Center (TCC)	Total Care Sevices (TCS)			Bay Area Center for Independent Living (BACIL)			
St. Mary's County, Maryland	Area Agencies on Aging (AAA)	Medical Management and Rehabilitations Services (MMARS)	The Coordinating Center (TCC)	Total Care Sevices (TCS)	Beatrice Loving Heart (BLH)	Service Coordination Inc. (SCI)		Southern Maryland Center for Independent Living (SMCIL)		
Talbot County, Maryland	Area Agencies on Aging (AAA)	Medical Management and Rehabilitations Services (MMARS)	The Coordinating Center (TCC)	Total Care Sevices (TCS)			Bay Area Center for Independent Living (BACIL)			
Washington County, Maryland	Area Agencies on Aging (AAA)	Medical Management and Rehabilitations Services (MMARS)	The Coordinating Center (TCC)	Total Care Sevices (TCS)	Beatrice Loving Heart (BLH)	Service Coordination Inc. (SCI)				
Wicomico County, Maryland	Area Agencies on Aging (AAA)	Medical Management and Rehabilitations Services (MMARS)	The Coordinating Center (TCC)	Total Care Sevices (TCS)			Bay Area Center for Independent Living (BACIL)			
Worcester County, Maryland	Area Agencies on Aging (AAA)	Medical Management and Rehabilitations Services (MMARS)	The Coordinating Center (TCC)	Total Care Sevices (TCS)			Bay Area Center for Independent Living (BACIL)			

2. State Standards.

Detail any difference between the state standards that will be applied under this waiver and those detailed in the State Plan coverage or reimbursement documents.

There are no differences between the state standards and those applied under the waiver.

D. Populations Affected by Waiver

1. Included Populations. The following populations are included in the waiver:

- Section 1931 Children and Related Populations
- Section 1931 Adults and Related Populations
- Blind/Disabled Adults and Related Populations
- Blind/Disabled Children and Related Populations
- Aged and Related Populations
- Foster Care Children
- Title XXI CHIP Children

2. Excluded Populations. Indicate if any of the following populations are excluded from participating in the waiver:

- Dual Eligibles
- Poverty Level Pregnant Women
- Individuals with other insurance
- Individuals residing in a nursing facility or ICF/MR
- Individuals enrolled in a managed care program
- Individuals participating in a HCBS Waiver program

- American Indians/Alaskan Natives
- Special Needs Children (State Defined). Please provide this definition.
- Individuals receiving retroactive eligibility
- Other (Please define): The population covered for this waiver is limited to applicants and enrollees of the 1915(c) Home and Community-Based Options Waiver.

Part II: Access, Provider Capacity and Utilization Standards

Timely Access Standards:

Describe the standard that the State will adopt (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State has adopted) defining timely Medicaid beneficiary access to the contracted services, i.e., what constitutes timely access to the service?

1. How does the State measure (or propose to measure) the timeliness of Medicaid beneficiary access to the services covered under the selective contracting program?

All SPAs are required to sign a provider agreement and adhere to the Provider Solicitation (Comprehensive Case Management and Supports Planning Services for Medicaid Long-Term Services and Supports). Timely access for case management is defined in the Provider Solicitation, *Freedom of Choice* Section and Section 3.5 *Supports Planning*. Case management agencies must establish contact and perform an initial visit with the referred applicant or participant within 14 calendar days of receipt of the referral. Additionally, Section 3.5.26 indicates unless waived, the case manager must meet with the participant in-person, or if directed by the Department, virtually, at the location where he or she receives services at least every 90 days.

Upon application for services, the Department will provide a packet of materials that includes brochures from all eligible case management and supports planning providers available in the applicant's area. Applicants are encouraged to contact case management and supports planning providers prior to selection. The applicant may choose a provider by contacting the Department or the chosen provider directly. This choice will be noted in *LTSSMaryland*. Applicants and participants who do not choose a provider within 21 days of receipt of the provider information packet will be auto assigned to a provider via *LTSSMaryland* to assure equal distribution of auto assignments among eligible providers. The applicant or participant will be able to change the auto-assigned provider at any time; however, once a provider is chosen by the participant, the 45-day limitation described below will apply.

Applicants and participants may choose to change their provider as needed, but no more than once every 45 calendar days. Once an applicant or participant chooses a new provider, the current provider will have 14 calendar days to complete their work with the applicant/participant. The new provider will receive a 14 calendar day notice and then become responsible for the provision of services on day 15. An applicant or participant may only request a change of provider after 45 calendar days with their current provider to ensure

adequate transition time and continuity of services. For example, if a participant who is already working with a supports planning provider chooses a new provider on January 1st, the change would be effective on January 15th. The participant is not eligible to request another change in provider until March 1st.

The provider will monitor annual redetermination dates, meet with the waiver participant to complete financial redetermination paperwork and facilitate the gathering of required documentation for the redetermination based on the requirements and timelines set forth in the Provider Solicitation.

2. Describe the remedies the State has or will put in place in the event that Medicaid beneficiaries are unable to access the contracted service in a timely fashion.

Providers are responsible to ensure compliance with all performance measures included in the Department's waiver applications through the development of a Quality Assurance (QA) and Quality Improvement (QI) Plan. The provider must develop and implement a QI/QA Plan, to be approved by the Department, to ensure compliance with all responsibilities and their associated timeframes contained in the Provider Solicitation. A provider must review its QI/QA Plan at least annually to evaluate its effectiveness in achieving the requirements noted in the Provider Solicitation and incorporate into the plan any additional performance measures requested by the Department as part of its comprehensive quality program. The State will implement a corrective action plan (CAP) for a provider that fails to meet timely access standards. The CAP will entail the allegations and supporting documentation.

During the current waiver period, **five (5)** CAP were issued for delays in supports planning services. No CAPs were issued for delays in assigning a supports planner. All agencies were required to submit the following in response to the timeliness CAP:

1. Description of the quality assurance plan in place to identify delays in timely services, including names of staff responsible for implementing the plan;
2. Description of the remediation process in place to address these delays;
3. Training materials for staff that include time frames and the quality assurance process;
4. An indication of what has been done to address this matter; and
5. An action plan that will be put in place to prevent a reoccurrence of this situation.

All CAP responses are reviewed and approved by the Department. **The Department will implement a remediation plan, including review of the QI/QA Plan, training materials, case consultations, business processes and other pertinent factors that may need to be addressed. The Department will evaluate and monitor the progress until the provider demonstrates the understanding to meet the standards set forth by the Department.**

Provider Capacity Standards:

Describe how the State will ensure (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State has ensured) that its selective contracting program provides a sufficient supply of contracted providers to meet Medicaid beneficiaries' needs.

1. Provide a detailed capacity analysis of the number of providers (e.g., by type, or number of beds for facility-based programs), or vehicles (by type, per contractor for non-emergency transportation programs), needed per location or region to assure sufficient capacity under the selective contracting program.

The State requires any AAA that chooses to provide supports planning to establish a maximum number of people they are able to serve. Based on these **projected** numbers, the State **solicits** case management providers and will award **to** ensure sufficient capacity to serve all applicants and participants. **The maximum ratio of applicants and participants to supports planners is 55:1. In the event that a provider exceeds/reaches capacity, their capacity will be reviewed and the applicant/participant may be referred to another agency, or may be placed on a waitlist until such time as an agency has capacity to provide the service. All agency capacity is reviewed monthly by the Department to ensure timeliness of services. The State monitors agency capacity overall and will re-solicit providers as needed. The State also works with existing agencies to increase capacity as needed within the system and, if applicable, target by region.**

2. Describe how the State will evaluate and ensure on an ongoing basis that providers are appropriately distributed throughout the geographic regions covered by the selective contracting program so that Medicaid beneficiaries have sufficient and timely access throughout the regions affected by the program.

There are always a minimum of two (2) case management agencies within a jurisdiction. The term of the current Provider Solicitation is April 1, 2021 through December 31, 2021 with three (3) annual option periods as indicated below:

- 1. January 1, 2022 to December 31, 2022**
- 2. January 1, 2023 to December 31, 2023**
- 3. January 1, 2024 to December 31, 2024**

The State monitors case management capacity per region/jurisdiction, at minimum, on a semi-annual basis via the "SPA Capacity Report" in LTSSMaryland. This report allows the State to evaluate applicant/participant distribution versus maximum allowable SPA capacity. This information assists the State with projecting regions/jurisdictions that may encounter insufficient case management services. The one-year terms in the Provider Solicitation allow the State to issue an amendment to solicit for additional case management providers, if needed. The Department also allows existing providers who have no pending CAPs to expand their capacity to meet additional needs in the event of insufficient capacity.

Utilization Standards:

Describe the State's utilization standards specific to the selective contracting program.

1. How will the State (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State) regularly monitor(s) the selective contracting program to determine appropriate Medicaid beneficiary utilization, as defined by the utilization standard described above?

To ensure appropriate utilization of services, agencies are required to set standards through the development and implementation of a QI/QA Plan. This Plan, which is submitted to the Department for review and approval, evaluates the effectiveness in achieving the requirements noted in the Provider Solicitation, as well as incorporating any additional performance measures requested by the Department. Additionally, the service needs of the applicant/participant are documented in the annual redetermination and the person-centered plan of service (POS). The Department reviews the POS, assessment and any reportable events (REs) to determine if the POS meets the needs of the participant. The Department also evaluates the utilization of services during annual SPA audits, as well as through weekly billing audits, and regular data reviews with the use of reports in *LTSSMaryland* to ensure the provision of services meets Department standards for utilization.

Additionally, participants have case management units identified on their POS, which are reviewed by the Department in *LTSSMaryland*. The State monitors the number of case management units utilized/billed versus the number of case management units on a participant's POS via reports in *LTSSMaryland* to monitor utilization.

2. Describe the remedies the State has or will put in place in the event that Medicaid beneficiary utilization falls below the utilization standards described above.

The Department will issue a CAP to any SPA that falls below the utilization standards outlined in the Provider Solicitation or is noncompliant with the Department's program regulations and policies.

Part III: Quality

Quality Standards and Contract Monitoring:

1. Describe the State's quality measurement standards specific to the selective contracting program.

a. Describe how the State will (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State):

i. Regularly monitor(s) the contracted providers to determine compliance with the State's quality standards for the selective contracting program.

Agencies must demonstrate the quality of supports planning services provided through an annual evaluation of their effectiveness in achieving the requirements by way of their QI/QA plan. This plan must indicate how data will be collected through evaluation activities to achieve full compliance with all requirements of the Provider Solicitation. Each SPA is provided technical assistance to help identify issues that needed remediation (not complaint with the Solicitation). Additionally, agency performance is reviewed through comprehensive client record reviews and an annual audit.

The State will require a CAP and implement a remediation plan for an agency that fails to meet the quality standards. In the event the providers fail to meet standards under the remediation plan, the State will take action to terminate the designation as a case management provider and transition all participants to other providers identified through the competitive solicitation process.

The State **also** has an **RE** policy that is used to follow-up on significant incidents and complaints for the Home and Community-Based Options Waiver as well as State Plan - Community First Choice (**CFC**) and Community Personal Assistance Services (**CPAS**) - programs. Once an **incident and/or** complaint is received by the State, **the Department** will review the findings and supporting documentation, follow-up with appropriate entities/parties, and if necessary, determine and implement appropriate action, such as recommending a CAP. The policy in its entirety may be found at:

<https://health.maryland.gov/mmcp/longtermcare/Resource%20Guide/12.%20Reportable%20Events/RE%20Policy%20Updated%201-1-17.pdf>.

Providers are **also** monitored with regard to their performance **as it relates to** participant **health and welfare through the performance measures in Section G** of the 1915(c) application.

ii. Take(s) corrective action if there is a failure to comply.

The State will require a **CAP** for a provider that fails to meet quality standards **established through the Provider Solicitation**. In the event the providers fail to meet standards under the CAP, the State will take action to terminate the designation as a case management provider and transition all participants to other providers identified through the competitive solicitation process.

2. Describe the State's contract monitoring process specific to the selective contracting program.

a. Describe how the State will (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State):

i. Regularly monitor(s) the contracted providers to determine compliance with the contractual requirements of the selective contracting program.

By submitting a proposal for the Provider Solicitation, the provider agrees to comply with all requirements noted in the Provider Solicitation, as well as those noted in the Medicaid Provider Agreement. The provider also agrees to comply with all applicable regulations, specifically COMAR 10.09.20, 36, 54, 81 and 84 and all applicable CPAS, CFC, Home and Community-Based Options Waiver and Increased Community Services program policies. The Department may terminate the agreement with the SPA at any time by notifying the provider in writing. If the provider wishes to terminate its agreement with the Department, the provider must submit a transition plan that clearly describes how applicants/participants will be assisted regarding the selection of a new provider, transition of files and other data in a Health Insurance Portability and Accountability Act of 1996 (HIPAA)-compliant manner and the reason for termination.

The Department reviews SPA data, including caseload and activities maintained in *LTSSMaryland*, on a quarterly basis to identify trends or issues that may require training, policy clarification, process improvements or other follow-up. Agency performance is also reviewed through an annual audit. Should an agency fall below the standards set forth by the Department during the audit, the agency will be placed on a Quality Improvement Plan (QIP) that outlines a work plan to remediate any deficiencies found during the audit. The QIP will remain in place until the Department has determined that the agency is at 100% compliance with the Provider Solicitation and has an ongoing process to monitor adherence to the standards set forth by the Department.

ii. Take(s) corrective action if there is a failure to comply.

LTSSMaryland contains data related to service provision, including dates of services, activities performed and billing. The Department will review reports to monitor timeliness and overall compliance with the requirements of the Provider Solicitation. The State will require a CAP for a provider that fails to meet requirements. In the event the providers fail to meet the contractual requirements under the CAP, the State will take appropriate action as needed. The Department may terminate the agreement at any time by notifying the provider in writing. If the provider wishes to terminate its agreement with the Department, the provider must submit a transition plan that clearly describes how applicants/participants will be assisted regarding the selection of a new provider, transition of files and other data in a HIPAA-compliant manner and the reason for termination.

Coordination and Continuity of Care Standards:

Describe how the State assures that coordination and continuity of care is not negatively impacted by the selective contracting program.

The selective contracting program assures coordination and continuity of care by holding the selected case management entities to the qualifications and performance standards outlined in the Provider Solicitation. Since the competitive solicitation process is not associated with funding, it allows the Department to solely focus on selecting entities that have demonstrated a commitment to supporting the coordination and continuity of care standards

and goals of the Department while preventing conflicts of interest in their proposal. This selective contracting program improves coordination and continuity of care by limiting the number of agencies, which increases the Department's ability to monitor service utilization via reports in *LTSSMaryland*. The reports allow the Department to monitor the number of units of service budgeted on POS versus those utilized by the participant, enrollment time frames, REs and other quality indicators.

Part IV: Program Operations

Beneficiary Information:

Describe how beneficiaries will get information about the selective contracting program.

Upon application for services, the Department will provide a packet of materials that includes brochures from all eligible case management and supports planning providers available in the applicant's area. Applicants are encouraged to contact case management and supports planning providers prior to selection. The applicant may choose a provider by contacting the Department or the chosen provider directly. This choice will be noted in *LTSSMaryland*. Applicants and participants who do not choose a provider within 21 days of receipt of the provider information packet will be auto assigned to a provider via *LTSSMaryland* to assure equal distribution of auto assignments among eligible providers. The applicant or participant will be able to change the auto-assigned provider at any time; however, once a provider is chosen by the participant, the 45-day limitation described above will apply.

The packet of information includes brochures provided by each case management provider. Applicants from nursing facilities will receive this information through the Money Follows the Person Options Counselors. The AAAs and additional providers identified through the competitive solicitation are also responsible for providing required information to applicants/participants. Applicant/participants assigned to a case management provider that is being terminated will be notified by mail and contacted by telephone to notify them of the change in provider status. Prior to termination, participants will have the opportunity to choose a new case management provider. If the participant does not select a new provider, one will be automatically assigned to him/her.

Individuals with Special Needs:

The State has special processes in place for persons with special needs (Please provide detail).

Section B – Waiver Cost-Effectiveness & Efficiency

Efficient and economic provision of covered care and services:

1. Provide a description of the State's efficient and economic provision of covered care and services.

The State estimates that applicants and participants will receive 3 hour per month of case

management which equals **\$224.04** per month at the rate of **\$18.67** per 15-minute unit. The pre-waiver **per member, per month** (PMPM) cost has been projected to be **\$262.52**, based on historical PMPM costs, which were paid at a flat administrative amount per participant then adjusted for the standard 2.5% **(in waiver years one and two)** or **3% (in waiver years three, four and five)** annual rate increase. These projections reflect reduced utilization of waiver case management services as many waiver participants receive the service through the CFC program.

2. Project the waiver expenditures for the upcoming waiver period.

Year 1 from: **4/1/2022 to 6/30/2022**

Trend rate from current expenditures (or historical figures): N/A

Projected pre-waiver cost: **\$3,306,176.88**

Projected waiver cost: **\$2,821,559.76**

Difference: **\$484,617.12**

Year 2 from: **7/1/2022 to 6/30/2023**

Trend rate from current expenditures (or historical figures): **3%**

Projected pre-waiver cost: **\$14,166,796.80**

Projected waiver cost: **\$12,089,977.90**

Difference: **\$2,076,818.90**

Year 3 from: **7/1/2023 to 6/30/2024**

Trend rate from current expenditures (or historical figures): **3%**

Projected pre-waiver cost: **\$15,176,566.90**

Projected waiver cost: **\$12,951,658.60**

Difference: **\$2,224,908.30**

Year 4 from: **7/1/2024 to 6/30/2025**

Trend rate from current expenditures (or historical figures): **3%**

Projected pre-waiver cost: **\$16,255,201.70**

Projected waiver cost: **\$13,871,913.80**

Difference: **\$2,383,287.90**

Year 5 from: **7/1/2025 to 6/30/2026**

Trend rate from current expenditures (or historical figures): **3%**

Projected pre-waiver cost: **\$17,413,227.40**

Projected waiver cost: **\$14,859,703.80**

Difference: **\$2,553,523.56**